

## Agency Benefits Coordinator Meeting Cancel Request Form/ SQE

## **Special Enrollment Provisions**

Special Enrollment Provisions is defined by federal law, and allows employees and dependents to enroll in coverage under certain conditions outside the annual Open Enrollment Period.



### **Life Events**

 Life Events are qualifying events that result in adding dependents that are newly eligible.

#### **Examples:**

- Marriage
- Birth/Adoption







## Special Qualifying Events (SQE)





#### What Forms to Submit?

- Enrollment Change Application: This form should be used to enroll or make changes to coverage.
- Cancel Request Form: This form should be used to terminate coverage.
- When enrolling an employee or dependent due to a SQE or Live Event, the application must be submitted within 60 days of the event.



## New vs. Old: Enrollment Change Application

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## New vs. Old: Cancel Request Form







STATE OF TENNESSEE GROUP INSURANCE PROGRAM INSURANCE CANCEL REQUEST APPLICATION State of Tennessee - Department of Finance and Administration - Benefits Administration **PARTIMERS** FOR HEALTH FOR EMPLOYEE

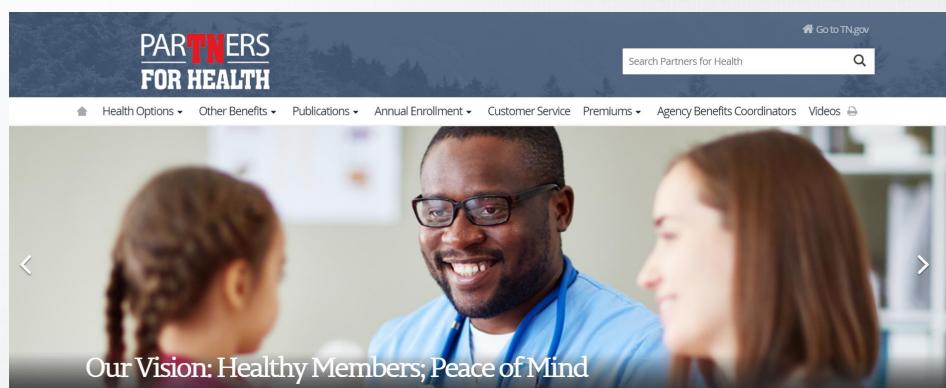
NAME	EDISONID	EMPLOYER GROUP	LOCAL ED LOCAL GOV		
PART 1 — PARTICIPANT(S) CANCELING COVERAGE (A	TTACH A SEPARATE	SHEET IF NECESSARY)			
I request to cancel   medical   dental   STD   LTD   coverage on the participant(s) below due to:	vision OFSA/me	idical DFSA/dep care D	FSA/limited Voluntary ADBD		
Reason marked in Part 2 below					
Prepaid dental: no participating general dentist within a	40-mile radius of my h	ome (skip Parts 2 and 3 bel	ow)		
Disability: requires 30 days advance written notice (skip P	arts 2 and 3 below)				
☐ Employee ☐ Spouse ☐ Chādiren) (names):					
INSTRUCTIONS					
You and/or your dependent(s) may only cancel coverage und of the following events. (Note: STD and/or LTD may be cancel			annual enrollment period except for one		
You and/or your dependent(s) may cancel coverage if you qualify may cancel. You have 60 days from a qualifying e			e reasons listed below. Only persons who		
If enrolled in the prepaid dental option and there is no p will be the last day of the month that this form is receive			us of your home. The coverage end date		
The purchase of a private policy is not a reason for cancellation	in of this coverage. Sub	bmit all documents to your	agency benefits coordinator.		
PART 2 — REASON TO REQUEST TO CANCEL					
REASON	DOCUMENTATION RE	EQUIRED			
Marriage, divorce, legal separation, annulment	Copy of marriage certificate or divorce decree or legal paperwork signed by judge and proof of other coverage (see #1 above)				
Birth, adoption, placement for adoption	Copy of birth certificate or adoption documents and proof of other coverage (see #1 above)				
Death of spouse, dependent	Copy of death certificate				
New employment, return from unpaid leave, change from part-time to full-time employement (spouse or dependent)	Letter on employer's company letterhead certifying date of insurance eligibility, date of return from unpaid leave or change in employment status				
Entitlement to Medicare, Medicald, TRICARE	Letter of entitlement from Medicare, Medicald or TRICARE or copy of new ID card				
Court decree or order	Copy of court decree	e or order signed by Judge			
Open enrollment	Letter, on company letterhead, certifying date of eligibility for other coverage				
A change in your place of residence or workplace out of the national service area (i.e., move out of the U.S.)	Letter stating date of	flocation change with me	mber's new address		
Marketplace Enrollment	I attest that I am eno	olled or intend to enroll in	the Marketplace		
PART 3 — REQUESTED COVERAGE END DATE					
The coverage end date may either be the last day of the moni coverage or the last day of the month that the event occurred		y date of other LAST	DAY COVERAGE TO BE ACTIVE (MM/DO/YY)		

unpaid leave  Entitlement to Medicare, Medicaid or TRICARE Letter of entitlement from Medicare, Medicaid or TRICARE or copy of new It  Birth Copy of birth certificate and proof of other coverage (see #1 above)  Divorce or legal separation Copy of divorce decree or legal separation paperwork signed by judge and of other coverage (see #1 above)  Court decree or order  Copy of court decree or order signed by judge			Eddonio	Employer Group:UTTERStateLocal Gov				
Becoming newly eligible for other coverage (mark reason in Part 2 below)  Prepaid dental only; no participating general dentist within 40 miles of my home (skip Parts 2 and 3 below)  Employee Child (provide name):  Spouse Child (provide name):  Spouse Child (provide name):  Stribictions  Ou and/or your dependent(s) may only cancel coverage under the state group insurance program during the annual enrollment transference descept for one of the following events:  1. If you and/or your dependent(s) become newly eligible for coverage under another plan (proof is required and only the individual or individuals who become newly eligible for coverage under another plan (proof is required and only the individual or individuals who become newly eligible for coverage may cancel). You have 60 days from the date that you and/or your dependent(s) become newly eligible for coverage may cancel). You have 60 days from the date that you and/or your dependent(s) become newly eligible for coverage to submit documentation.  2. if enrolled in the prepaid dental option and there is no participating general dentist within a 40-mile radius of your home. The coverage and a private policy is not a reason for cancellation of this coverage. Submit all documents to your agency benefits coordina NATI 2—ILEASON PARTICIPANT(5) HAS ECOME NEWLY ELIGIBLE UNIDER ANOTHER PLAN  Marriage Copy of marriage certificate and proof of other coverage (see #1 above)  Marriage Copy of marriage certificate and proof of other coverage (see #1 above)  Mow employment (self, spouse or dependent)  Letter, on company letterhead, from employer certifying date of eligibility Return from unpaid leave  Letter, on company letterhead, from employer certifying date of eligibility of other coverage (see #1 above)  Divorce or legal separation  Copy of divorce decree or legal separation paperwork signed by judge and of other coverage (see #1 above)  Copy of divorce decree or order signed by judge of the reational service area (i.e., move out of the U.S.)  From part-time to f	ART 1 - PARTIC	IPANT(5) CANCELING COVERAG	E (attach a separate she	ret if necessary)				
Employee Child (provide name):    Spouse Child (provide name):	Becoming ner	wly eligible for other coverage (mar	k reason in Part 2 below)					
Spouse Child (provide name):  Statuctions  Ou and/or your dependent(s) may only cancel coverage under the state group insurance program during the annual enrollment transference accept for one of the following events:  If you and/or your dependent(s) become newly eligible for coverage under another plan (proof is required and only the individual or individuals who become newly eligible for other coverage may cancel). You have 60 days from the date that you and/or your dependent(s) become newly eligible for coverage to submit documentation.  If enrolled in the prepaid dental option and there is no participating general dentist within a 40-mile radius of your home. The coverage date will be the last day of the month that this form is submitted to Benefits Administration.  The purchase of a private policy is not a reason for cancellation of this coverage. Submit all documents to your agency benefits coordina was a private policy is not a reason for cancellation of this coverage. Submit all documents to your agency benefits coordina was a private policy is not a reason for cancellation of this coverage. Submit all documents to your agency benefits coordina was a private policy is not a reason for cancellation of this coverage. Submit all documents to your agency benefits coordina was a private policy in the month that this form is submitted to Benefits Administration.  BASON  DOCUMENTATION REQUIRED  Copy of marriage certificate and proof of other coverage (see #1 above)  Adoption / placement for adoption  Copy of adoption documents and proof of other coverage (see #1 above)  Letter, on company letterhead, from employer certifying date of return from ungaid leave  Letter, on company letterhead, from employer certifying date of return from ungaid leave  Copy of divorce decree or legal separation paperwork signed by judge and of other coverage (see #1 above)  Copy of divorce decree or order signed by judge  Open emrollment  Letter, on company letterhead, from employer certifying change in status dependent)  Letter, on	-							
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Adoption / placement for adoption  Copy of adoption documents and proof of other coverage (see #1 above)  New employment (self, spouse or dependent)  Letter, on company letterhead, from employer certifying date of eligibility  Letter, on company letterhead, from employer certifying date of return from unpaid leave  Letter of entitlement from Medicare, Medicaid or TRICARE  Letter of entitlement from Medicare, Medicaid or TRICARE or copy of new It  Birth  Copy of birth certificate and proof of other coverage (see #1 above)  Divorce or legal separation  Copy of divorce decree or legal separation paperwork signed by judge and of other coverage (see #1 above)  Copy of ourt decree or order  Copy of ourt decree or order signed by judge  Open enrollment  Letter, on company letterhead, certifying date of eligibility for other coverage (see #1 above)  Letter, on company letterhead, certifying date of eligibility for other coverage (see #1 above)  Letter stating date of location change with member's new address of the LS.)  From part-time to full-time employment (spouse or dependent)  Marketplace Enrollment  Lattest that I am enrolled or intend to enroll in the Marketplace	Control of the last of the las		NAME AND ADDRESS OF TAXABLE PARTY.	and Artist of a Marian Co. Hartist				
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Return from unpaid leave	Adoption / pl	acement for adoption	Copy of adoption	Copy of adoption documents and proof of other coverage (see #1 above)				
Entitlement to Medicare, Medicaid or TRICARE   Letter of entitlement from Medicare, Medicaid or TRICARE or copy of new It	New employs	nent (self, spouse or dependent)	Letter, on compar	ny letterhead, from employer certifying date of eligibility				
Birth Copy of birth certificate and proof of other coverage (see #1 above)  Divorce or legal separation Copy of divorce decree or legal separation paperwork signed by judge and of other coverage (see #1 above)  Copy of divorce decree or legal separation paperwork signed by judge and of other coverage (see #1 above)  Copy of court decree or order signed by judge  Open enrollment  Letter, on company letterhead, certifying date of eligibility for other coverage (see #1 above)  A change in your place of residence or workplace out of the axional service area (i.e., move out of the U.S.)  From part-time to full-time employment (spouse or dependent)  Marketplace Enrollment I attest that I am enrolled or intend to enroll in the Marketplace	Return from u	npaid leave		Letter, on company letterhead, from employer certifying date of return from unpaid leave				
Divorce or legal separation  Copy of divorce decree or legal separation paperwork signed by judge and of other coverage (see #1 above)  Copy of court decree or order  Copy of court decree or order signed by judge  Letter, on company letterhead, certifying date of eligibility for other coverage  A change in your place of residence or workplace out of the national service area (i.e., move out of the U.S.)  From part-time to fulf-time employment (spouse or dependent)  Marketplace Enrollment  I attest that I am enrolled or intend to enroll in the Marketplace	Entitlement to	Medicare, Medicaid or TRICARE	Letter of entitlem	Letter of entitlement from Medicare, Medicaid or TRICARE or copy of new ID co				
of other coverage (see #1 above)  Copy of court decree or order Copy of court decree or order signed by judge  Copy of court decree or order signed by judge  Letter, on company letterhead, certifying date of eligibility for other covera  A change in your place of residence or workplace out of the national service area (i.e., move out of the U.S.)  From part-time to full-time employment (spouse or dependent)  Marketplace Enrollment  I attest that I am enrolled or intend to enroll in the Marketplace	Birth	71 8	Copy of birth cert	Copy of birth certificate and proof of other coverage (see #1 above)				
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dependent				Letter stating date of location change with member's new address				
	dependent)		100					
ART 3 — REQUESTED COVERAGE END DATE	Marketplace E	nrollment	lattest that I am e	nvolled or intend to enroll in the Marketplace				
	ART 3 - REQUE	STED COVERAGE END DATE						



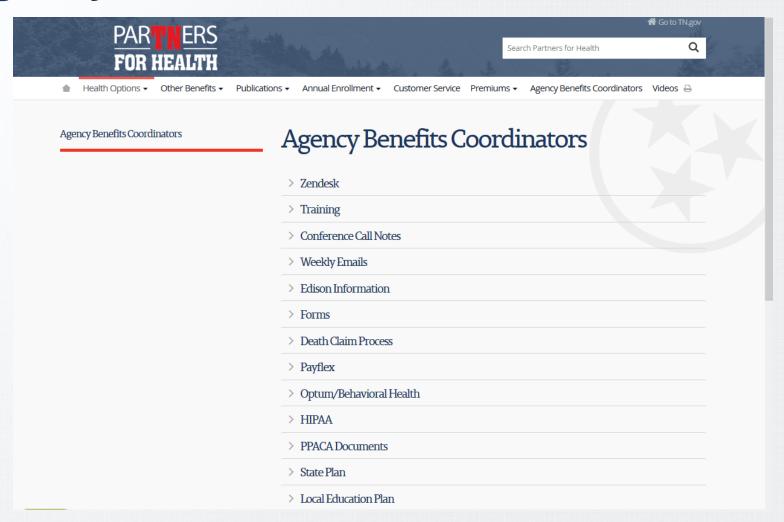
#### Places to find Forms...

www.tn.gov/partnersforhealth.html





## **Agency Benefits Coordinators Tab**





## **Publication Tab**

#### Publications

**Publications** 

Forms

#### **Insurance Forms**

- > Health, Dental, Vision, Disability
- > Life
- > Retirement
- > Leave of Absence
- > Miscellaneous
- > Flexible Benefits Enrollment
- > Flexible Benefits Reimbursement



# Questions?

